Washington State Department of Social & Health Services
MAA Medical Assistance Administration

# MEDICALCOVERAGE INFORMATION

| COMMUNITY SERVICES OFFICE (CSO/HCS) | CSO/HCS TELEPHONE NUMBER |
|---|---|
| CLIENT NAME | CLIENT TELELPHONE NUMBER |
| CLID | DATE |

**COOPERATION**

☐ 1. DCS referral: YES NO
a. Required? ☐ ☐
b. Made? ☐ ☐

☐ 2. DCS/TPL/Good Cause established ☐ ☐

**INSTRUCTIONS:** IMPORTANT INFORMATION: The purpose of this form is to find out if you have Private Insurance and/or Medicare. You can have private insurance and/or Medicare and still be covered by Medicaid. If you are covered by Medicaid and are paying for private health insurance, we might be able to help you with your premium. When you have completed this form, please return it to your local Community Services Office (CSO/HCS). You may use additional paper if you need more space. For more information on the premium payment program or help in completing this form call 1-800-562-6136.

**A. Do you have Medicare?**

☐ Yes ☐ No

IF YES, NAME OF PERSON WITH MEDICARE — MEDICARE CLAIM NUMBER

NAME OF PERSON WITH MEDICARE — MEDICARE CLAIM NUMBER

**B. Do you have health or dental insurance coverage?** ☐ Yes ☐ No

**Have you had health or dental insurance coverage in the past 12 months?** ☐ Yes ☐ No

This includes any insurance you, or someone else pays for, such as private insurance, school insurance, Medicare supplements, group insurance from your employer, etc. If yes, complete the following:

| HEALTH OR DENTAL POLICY NUMBER 1 | | | HEALTH OR DENTAL POLICY NUMBER 2 | | |
|---|---|---|---|---|---|
| INSURANCE COMPANY NAME | | | INSURANCE COMPANY NAME | | |
| INSURANCE COMPANY ADDRESS | | | INSURANCE COMPANY ADDRESS | | |
| INSURANCE COMPANY TELEPHONE NUMBER | | | INSURANCE COMPANY TELEPHONE NUMBER | | |
| SUBSCRIBER NAME | SUBSCRIBER SSN | | SUBSCRIBER NAME | SUBSCRIBER SSN | |
| POLICY NUMBER | GROUP NUMBER | | POLICY NUMBER | GROUP NUMBER | |
| EMPLOYER NAME/GROUP NUMBER | | | EMPLOYER NAME/GROUP NUMBER | | |
| UNION NAME AND LOCAL NUMBER | | | UNION NAME AND LOCAL NUMBER | | |
| SUBSCRIBER BIRTH DATE | POLICY BEGIN DATE | POLICY END DATE | SUBSCRIBER BIRTH DATE | POLICY BEGIN DATE | POLICY END DATE |

List who is covered by this policy:

| NAME | SOCIAL SECURITY NUMBER | BIRTHDATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List who is covered by this policy:

| NAME | SOCIAL SECURITY NUMBER | BIRTHDATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Check the services your policy covers:

☐ In-patient hospital care ☐ Nursing home care
☐ Out-patient hospital care ☐ Dental care
☐ Prescription drugs/supplies ☐ Physician services
☐ Eye glasses/vision care
☐ Other (ambulance, therapy, chiropractic, etc.)

Check the services your policy covers:

☐ In-patient hospital care ☐ Nursing home care
☐ Out-patient hospital care ☐ Dental care
☐ Prescription drugs/supplies ☐ Physician services
☐ Eye glasses/vision care
☐ Other (ambulance, therapy, chiropractic, etc.)

**C. Do you have Long Term Care Coverage?** ☐ Yes ☐ No If yes, complete the following:

Nursing Home Coverage? ☐ Yes ☐ No Assisted Living Coverage? ☐ Yes ☐ No In-Home Care Coverage? ☐ Yes ☐ No

| INSURANCE COMPANY NAME | | INSURANCE COMPANY ADDRESS | | |
|---|---|---|---|---|
| TELEPHONE NUMBER | GROUP NUMBER | POLICY NUMBER | POLICY BEGIN DATE | **POLICY END DATE** |

| MEDICAL COVERAGE INFORMATION Page 2 | CSO/HCS | CLID |
|---|---|---|

**D. Are there any children or an unborn child in your home for whom a noncustodial parent is responsible?**

☐ Yes ☐ No If yes, complete the following information about each noncustodial parent.

| NAME AND ADDRESS AND TELEPHONE NUMBER | DATE OF BIRTH | SOCIAL SECURITY NUMBER | CHILD(REN) | COURT ORDER FOR MEDICAL COVERAGE |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

**E. Do you have Military Benefits?**

TRICARE ☐ Yes ☐ No CHAMPVA ☐ Yes ☐ No Veterans Benefits ☐ Yes ☐ No

| IF YES, SPONSOR'S NAME | SPONSOR'S SOCIAL SECURITY NUMBER | VETERANS CLAIM NUMBER |
|---|---|---|
| | | |

**F. Have you or the person you are applying for had an accident requiring medical care?** ☐ Yes ☐ No If yes, answer the following:

| 1. DATE OF ACCIDENT | 2. CHECK WHERE THE ACCIDENT HAPPENED |
|---|---|
| | ☐ Store/business ☐ Other person(s) home/property ☐ Place of employment ☐ Other: ☐ Automobile ☐ School ☐ Home |

a. Address of accident (street, city, and state): _____

b. Check if the patient was the ☐ driver; ☐ passenger; ☐ pedestrian; ☐ guest; ☐ customer; ☐ employee; ☐ resident.

c. Were other automobiles involved? ☐ Yes ☐ No If yes, list name and address of other drivers:

| 3. Name(s) of person(s) hurt in the accident | | 4. How did the accident happen? |
|---|---|---|
| NAME | TYPE OF INJURY | |
| | | |
| | | |
| | | |
| | | |

5. Is an insurance company involved? ☐ Yes ☐ No If yes, give the name of the insured: _____

Name and address of company:

| CLAIM NUMBER | POLICY NUMBER | ADJUSTER NAME | TELEPHONE NUMBER |
|---|---|---|---|
| | | | |

6. Did you file another claim for the accident? ☐ Yes ☐ No If yes, give the claim number(s):

| LABOR AND INDUSTRIES CLAIM NUMBER | SELF INSURED CLAIM NUMBER | CRIME VICTIM'S CLAIM NUMBER | OTHER |
|---|---|---|---|
| | | | |

7. Is a lawyer involved? ☐ Yes ☐ No If yes, give the name, address, and telephone number:

Claim Pending? ☐ Yes ☐ No Claim Settled? ☐ Yes ☐ No If yes, date settled:

8. What financial/medical benefits did you receive or do you expect to receive because of your injury? Explain:

I hereby authorize the release of any information necessary regarding payments of premiums or coverage of any insurance policy for which I am the beneficiary or the person obtaining coverage, to the Department of Social and Health Services for the purpose of coordination of health/medical benefits. (WAC 388-505-0540)

| SIGNATURE | DATE |
|---|---|
| | |

## How to use your private health insurance and medical ID card (coupon) to receive health care.

Q: **If I have private insurance, will Medicaid still help me?**

A: Yes. Having Medicaid along with your private insurance really helps. As long as you qualify for Medicaid, we may pay co-pays, deductibles and services your insurance does not cover.

Q: **If I have both private insurance and Medicaid what do I tell my doctors or other medical providers?**

A: It is important that you go to providers who will take both your private insurance and Medicaid ( medical ID card/coupon). When you go to your doctor or other medical provider(s), show **both** the private health insurance card and your medical ID card. Ask if they will accept your private insurance and if they will take your medical ID card for co-pays, deductibles and services not covered by your insurance. If your provider does not accept your insurance and Medicaid you will be responsible for any health care you receive.

Q: **What should I do if my doctors or other providers say they won't take my private insurance or medical ID card?**

A: You should look for providers who will accept both your Medicaid and private insurance. You may need to call your insurance company for assistance in locating providers in your area.

Q: **What happens if my private insurance doesn't cover a service?**

A: Your doctor will bill your private insurance first. If the service isn't covered by your insurance but is covered by Medicaid, they will bill Medicaid for payment. To make sure there are no problems, always make sure your provider will take our medical ID card and bill Medicaid.

Q: **What do I need to do to have you pay my health insurance premium?**

A: Call us. We will need information about your health insurance, your premium amount, when it is due and whether you or your employer pays the premium. Once we have this information we will let you know if we can pay your premium.

Q: **What do I need to do to have Medicaid pay for my co-pays and deductibles?**

A: Call us to make sure we have your private health insurance information on file. Your four digit insurance code is printed on your medical ID card under the Insurance column. This information tells the provider which insurance company to bill and that you are not responsible for co-pays or deductibles when you receive Medicaid covered services. If there is a question about this you or your provider can call us.

Q: **Will I be asked to pay the difference between what Medicaid pays and what my provider bills?**

A: No. When doctors and other providers work with Medicaid, they agree to take what Medicaid pays and not bill you for any difference. If you're ever billed, call us immediately. You cannot be billed for a Medicaid covered service.

Q: **What if my private insurance ends or changes?**

A: It is important to call and let us know of any changes to your insurance coverage. We will update your file and you will continue to receive medical care through Medicaid as long as you qualify.

Q: **If I have long-term care (LTC) insurance, will Medicaid still help me?**

A: Yes. Medicaid can help pay your LTC costs when you are in your own home, an assisted living facility, an adult family home, or a nursing facility if your LTC insurance will not pay for all of the costs. If the insurance pays you directly you must send the insurance checks to the Department of Social and Health Services (DSHS).

Q: **Why should I keep my LTC insurance if I qualify for Medicaid?**

A: There is no guarantee that you will always qualify for Medicaid. You may receive additional sources of income or assets that could cause your eligibility to be terminated or the legislature might reduce funding for some programs. If you cancel your LTC insurance you may not be able to get it back. LTC insurance benefits will also reduce any obligations against your estate when you pass away.

Q: **What if I have other questions?**

A: If you have questions about your private health insurance, call your plan directly. For additional assistance with using your medical ID card with your private insurance, call us at the number below.

**TOLL FREE 1-800-562-6136 Coordination of Benefits**
**Monday – Friday 8:00 a.m. to 4:30 p.m.**